THE FATE OF BRITISH TRADITIONS IN THE UNITED STATES AS SHOWN IN MEDICAL EDUCATION AND IN THE CARE OF THE MENTALLY ILL 1750-1850*

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SINCE the early history of the United States can be viewed as an extension or excrescence of the history of Great Britain, it is almost obligatory for an American to examine the British cultural heritage and to consider the vicissitudes that it may have undergone in crossing the Atlantic Ocean. But even in the restricted realm of medicine the processes and events are too numerous and too complex to be reviewed satisfactorily in a periodical journal. Hence the present review will be limited to two areas—medical education and the care of the mentally ill.

AMERICAN MEDICAL EDUCATION[1]

The experience of Pennsylvania and Maryland can be taken as a prototype. In the early years of the 18th century young Americans who wanted to study medicine undertook apprenticeship with established physicians. The term was ordinarily five to seven years. Any practitioner might act as preceptor, and the quality of the instruction was subject to little or no supervision. Included among the preceptors were some of the best physicians in the community. John Redman (1722-1808)[2] is an example.

After preliminary education in the classics and a medical apprenticeship in Philadelphia he practiced medicine in Bermuda. With money

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1. In this part of the presentation I shall often follow a) Norwood, W. F.: *Medical Education in the United States Before the Civil War.* Philadelphia, University of Pennsylvania Press, 1944 and b) Miller, G.: Medical education in the American colonies. *J. Med. Educ. 31*:82-94, 1956.

2. Redman, John, by H. R. Viets. *Dictionary of American Biography* (hereafter cited as DAB). New York, Scribner's, 1935, vol. 8, part 1, p. 443.

saved from practice and added to a small inheritance, he went to Edinburgh in 1746, working chiefly with Alexander Monro, *primus*. He then took the medical doctorate in Leyden (1748) and studied in Paris and at Guy's Hospital. Taking up medical practice in Philadelphia, he became attending physician to Pennsylvania Hospital. He was preceptor to John Morgan, Caspar Wistar, Benjamin Rush, and scores of others. His ability is well documented. Men like Redman had much to offer the student, and the system of preceptorship was not devoid of merit. The same sour comment has been made about every subsequent system, not excluding that which now exists.

As early as 1730 or 1731 private courses began to be given in Philadelphia. These usually were on anatomy and at times included demonstrations on the cadaver. One such course was given by Thomas Cadwalader (1707?-1799),[3] another Philadelphian. After apprenticeship to an uncle unsurprisingly named Evan Jones, Cadwalader spent a year with William Cheselden and then took courses at the University of Rheims. Returning to Philadelphia, he gave anatomical demonstrations and dissections. He is thought to have been the first teacher of practical anatomy in British North America.

Courses given on this plan were part of no collegiate curriculum and led to no academic degree. In this respect they resembled many courses given in Great Britain at that time.

Apprenticeship and private courses constituted most of what was available to the North American student in colonial times. But the ambitious, the eager, and the wealthy, demanding greater opportunities, came to Europe. The successive primacy of Leyden, Edinburgh, and London (and later of Paris and cities in Germany and Austria) is well known. In these famous centers the American student could visit casually, take systematic private courses, or enroll in regular fashion in the university and receive a regular degree. On returning to America the more energetic and progressive might teach.

An outstanding example is John Morgan (1735-1789),[4] a burning and shining light, and a slightly dubious character. He was the son of a merchant and was born in Philadelphia. In 1757 he was graduated from the College of Philadelphia, which later became the University of Pennsylvania. For six years he was the apprentice of John Redman. After

3. Cadwalader, Thomas, by F. R. Packard: *DAB*, vol. 2, part 1, pp. 400-01.
4. Bell, W. J., Jr.: *John Morgan, Continental Doctor*. Philadelphia, University of Pennsylvania Press, 1965.

prolonged medical service in the war against France he spent a year in London with Hewson, Fothergill, and the Hunters, then took the M.D. at Edinburgh (1763), studied anatomy in Paris, and visited Morgagni. He was admitted to membership in the Royal Academy of Surgery of Paris, the Royal Society of London, and a learned society in Rome, and was licentiate of the Royal Colleges of Physicians of London and Edinburgh.

Morgan returned to Philadelphia in 1765. While in Europe he had formed the plan of establishing a medical school in connection with the College of Philadelphia. His proposal was at once accepted and he became Professor of the Theory and Practice of Physic.

Morgan's coeval William Shippen (1736-1808)[5] reveals minor variations of the pattern. He was the son of a prominent physician. After graduation from the College of New Jersey (now known as Princeton University), he studied medicine for three years with his father. Later he was a pupil of William Hunter and became the friend of Fothergill. He took the M.D. degree at Edinburgh in 1761 and visited medical schools in Paris and Montpellier. After five years of medical study in Europe he returned to Philadelphia. Fothergill had sent under Shippen's care some anatomical models and drawings which were directed to the trustees of the Pennsylvania Hospital. With these as adjuvants, but relying even more on cadavers—a method learned from Hunter—Shippen in 1762 conducted courses in anatomy and later in midwifery. Three years later, in 1765, the College of Philadelphia instituted its medical school. Shippen became its professor of surgery and anatomy.

Morgan and Shippen were soon joined by the two remaining members of the professorial quadrumvirate, Adam Kuhn and Benjamin Rush. Kuhn,[6] after studying medicine in Pennsylvania with his father, spent about three years in Sweden with Linnaeus, then went to Edinburgh, where he received the M.D. degree in 1767. In 1768 he became professor of botany and materia medica in Philadelphia.

Benjamin Rush (1745-1813),[7] the last of the four original professors, was the son of a gunsmith. After obtaining the baccalaureate degree in arts at the College of New Jersey in 1760, he spent five years as an apprentice to Redman and attended the earliest lectures of Shippen and Morgan at the College of Philadelphia. In 1768 he received the

5. Shippen, William, by F. R. Packard. *DAB*, vol. 9, part 1, pp. 117-18.
6. Kuhn, Adam, by W. L. Jepson: *DAB*, vol. 5, part 2, pp. 510-11.
7. Rush, Benjamin, by Richard H. Shryock: *DAB*, vol. 8, part 2, pp. 227-31.

medical doctorate at Edinburgh, where he had been a pupil of Alexander Monro, *secundus;* Joseph Black; John Gregory; and William Cullen. He then studied in London at St. Thomas's Hospital, and in Paris. In 1769 he was made professor of chemistry in the College of Philadelphia.

The biographies of Morgan, Shippen, Kuhn, and Rush can serve as descriptions of the men and the forces that influenced colonial medical education near the end of the 18th century. All four men had been born in Pennsylvania. Three were the sons of native Pennsylvanians. Except for Rush, all were the sons of physicians or merchants. All had had American apprenticeships or the equivalent. After preliminary collegiate study, they had taken the medical doctorate at Edinburgh. All studied also in London and almost all studied or visited in France. Such were the well-trained and well-educated founders, assembled between 1765 and 1769 as the medical faculty of the College of Philadelphia. They were the outstanding academic physicians and not the average physicians—nor were they necessarily the best physicians—of colonial Pennsylvania.

From the moment of its birth, the school of medicine was part of the College of Philadelphia, an entity which had originated as early as 1740 and which ultimately became the University of Pennsylvania. Hence, the medical school was never independent. It was part of a larger educational establishment and, in addition, it had close and genuine connections with the Pennsylvania Hospital. At an early time medical students gained acceptance as apprentices of the Hospital.

In 1767 the new medical college published a description of its prerequisites and curriculum.[8] Candidates for the baccalaureate degree in physic, if they had not previously received a degree in any college, were required to satisfy the professors of their knowledge of Latin, natural science, and mathematics, to have served an apprenticeship, and to have learned pharmacy. At the medical college they were obliged to attend lectures in anatomy, materia medica, chemistry, and physic, and to attend at the hospital for a year. They then took private and public examinations. After the lapse of three additional years and the presentation of a thesis they might return for the doctoral degree.

In this system three traits are especially important: the school of medicine had high standards of admission, it was actually as well as nominally

8. Norwood, op. cit., p. 65.

part of a university, and it was designed in imitation of the University of Edinburgh. Let us now consider its fate.

From the viewpoint of formal and nominal academic requirements the decade which followed 1767 may be regarded as representing the highest level attained by the medical school of Philadelphia for many years to come. In retrospect it appears probable that the standards were set, by energetic idealists, at an impractically high level which was unsuited to the conditions that then prevailed in North America. In 1779, on an accusation of Toryism, the College of Philadelphia lost its charter. The college was reestablished in 1789 and in 1791 it was merged with the University of Pennsylvania. By 1789 it was evident that few bachelors of medicine would return for the doctorate. Therefore, the baccalaureate degree was abolished. For the doctoral degree the requirement was reduced to three years of study under a preceptor, followed by two years of study in the college. A thesis was required but it did not have to be in Latin.

In 1811 it was still the rule that the students must attend lectures for two years, but in actual fact they merely took the same course of lectures twice. Study in the hospital wards was again included among the formally announced requirements.

In 1807 three Baltimore physicians, appreciably less eminent than the Philadelphia medical *patres patriae*, established the College of Medicine of Maryland. Immediately afterward they secured a charter which provided that the college should be ruled by a board of regents composed of the college president and professors, together with the Board of Medical Examiners. The medical society of the state of Maryland was designated as patron but it did not provide financial support or exercise genuine control, those functions being discharged by the professors.

After the College had been in existence for five years it obtained a new charter, according to which power was lodged with a new board of regents composed of the professors and the provost. This board was autonomous and self-perpetuating. Its members, the professors, therefore, were in fact proprietors of the college. In the opinion of Flexner[9] and Norwood,[10] two principal students of the subject, the system thus created in Baltimore furnished the genesis of that distinctly and distinctively American institution, the proprietary medical school. Whether

9. Flexner, A.: *Medical Education in the United States and Canada.* New York, Carnegie Foundation for the Advancement of Teaching, 1910, p. 5.

10. Norwood, op. cit., pp. 229, 430.

or not this ascription should be accepted may depend on special studies in which proprietary medical schools are compared with American proprietary law schools. Such studies are likely to prove instructive.

Medical academies of the proprietary type—contemporaneous with Dotheboys Hall—spread rapidly. In the city of Baltimore, which already harbored the College of Medicine of Maryland, a capable malcontent obtained from the state legislature a charter for a new school, the Washington Medical College, which was opened in 1827.[11] It soon obtained for its faculty the autonomy characteristic of proprietary colleges. The neonate then attempted to become a university. But this metamorphosis did not eventuate and the medical school never transcended its limited scope. The end came, apparently through inanition, in 1851-1852. A resurrection lasted from 1867 to 1877.

The short and complex annals of this school were repeated by medical academies in all parts of the expanding country. The story was usually one of legislative petitions, charters, announcements, efforts, discontent, vituperation, resignation, secessions, lawsuits, and even duels. The classical description will be found, not in orthodox narcotic works of scholarship, but in Daniel Drake's *Narrative of the Rise and Fall of the Medical College of Ohio*,[12] a work reminiscent not of Gibbon but of Lucian.

Although it is true that the creation and operation of a medical school might be profitable to the proprietors, however profitless to students, it would be rash to assume that the predominant motives were always or necessarily financial; indeed, many an obscure or ephemeral faculty included the best men of its region. But these schools —inadequately equipped with money, cadavers, hospital facilities, and books—were foredoomed to early demise.

A chart[13] published long after these events shows that at one time or another between 1765 and 1913 there had been in the United States no less than 308 medical colleges, plus 118 institutions of questionable or fraudulent character. In the latter class, according to the official *index expurgatorius*, the greatest number were in Illinois and New York, other

11. Miller, G.: A nineteenth century medical school: Washington University of Baltimore. *Bull. Hist. Med.* *14*:14-29, 1943. The name of the institution was inconstant.

12. Drake, D.: *Narrative of the Rise and Fall of the Medical College of Ohio.* Cincinnati, Looker and Reynolds, 1822.

13. Life chart of the medical colleges of the United States. *J.A.M.A.* *61*:577-82, 1913.

states being less alert or less successful in the practice of educational malfeasance.

Fraudulent schools continue to exist in the United States, although not in medicine. On November 30, 1974 *The New York Times* reported allegations about vocational schools. It was estimated that 3,250,000 students were paying $2.5 billion a year to 10,000 vocational schools, the payments made to fraudulent schools being estimated at $50 million to $100 million.

Having summarized the history of American medical education from approximately 1750 to 1850, we must now attempt to discover some of the causes of the deterioration in the quality of American schools, a phenomenon accompanying the prodigious increase in their number.

Since the qualitative decline and the quantitative increase occurred in regions of great physical and climatic diversity, simple geographical factors cannot be blamed. The causes must be sought among social, economic, and historical conditions or processes.

The transfer of populations from areas of high culture in Europe to distant colonies which later became independent created a condition in which ideals and practices were generated at a center but their maintenance devolved upon a periphery. Other changes occurred at the same time, especially the migration of people from a continent which had many large cities to one which had few. Moreover, this was a migration from areas of high demographic density to areas where the people were few and widely dispersed. Wide dispersion created the need for medical care in remote and inaccessible places, a condition which must have favored amateur therapeutics and cultist practice more than orthodox medicine.

An additional fact has often been overlooked. Many men who practiced medicine also engaged in business, agriculture, or preaching, either simultaneously with their work as physicians or subsequently. Hence the large numbers of medical schools recorded in statistical compilations do not prove that a correspondingly large number of persons had been added permanently to the ranks of active medical practitioners.

These facts bear upon the numerical aspects. Of the qualitative decline the causes must be sought elsewhere. Probably the most important factors were egalitarianism and its consequence and corollary, the distrust of experts. These attitudes can best be illustrated by anecdotes.

Both Norwood[14] and Cordell[15] tell us that in 1807, when the Maryland legislature was considering the bill which would establish the College of Medicine of Maryland, it was remarked that among the seven members of the medical faculty there were three who did not have the doctoral degree. A friendly or biased legislator felt that this was unjust. The degree was thereupon conferred on those who lacked it, *nemine contradicente*. This egalitarianism and this disregard of tradition explain part of the course of American education, both nonmedical and medical —and much of the course of American life.

The tendency of the "Levellers" was no transient phenomenon. As late as 1911, a man named Randolph Winslow, a member of the Judicial Council of the Association of American Medical Colleges, said the following:

> We have been trying to establish as a requirement for the study of medicine a thing which is not demanded of a man to qualify him for the presidency of the United States, a chief justice, a legislator or any other high office. A man can hold any of our public offices without having seen the inside of a college, and yet we are demanding that before he is even qualified to study medicine he shall have a B.S. degree! . . . To say to a man that because he has not had certain specified training "you shall not be permitted to study medicine" is distinctly un-American and undemocratic and should not be tolerated.[16]

In the presence of egalitarian opinions and forces it is not astonishing that by 1842 most of the 26 states had never had laws for the regulation of medical practice or had repealed laws previously extant.[17]

This tendency was accompanied by other traits, some of which were self-contradictory. In addition to mentioning the well-known American eagerness, impatience, and interest in material prosperity, all of which have obvious bearing on the subject under discussion, Professor Henry Steele Commager, one of our most eminent historians, pointed out that the 19th century American venerated the law but tended to be lawless and to show disrespect for lawyers. Moreover, says Commager, "His attitude toward higher education was something of a paradox. Nowhere

14. Norwood, op. cit., p. 226.
15. Cordell, E. F.: *The Medical Annals of Maryland.* Baltimore, Williams and Wilkins, 1903, p. 57.
16. Winslow, R.: Discussion. *Proc. Ass. Amer. Med. Coll. 21*:23, 1911.
17. Norwood, op. cit., p. 406.

else in the western world did colleges multiply and flourish as in America, yet not until Eliot reformed Harvard and Gilman built the Johns Hopkins did he [the American] have a real university. No people was more avid of college degrees, yet nowhere else were intellectuals held in such contempt or relegated to so inferior a position; and in America alone the professor—invariably long haired and absent minded—was an object of humor."[18]

With respect to these and many other American culture traits we can hardly consult a more sagacious oracle than Alexis de Tocqueville, who visited the United States from 1831 to 1832 and published his observations in 1835 and 1840. Tocqueville noticed that during the 50 years which had elapsed since the American Revolution the quality of American statesmen had "dwindled most remarkably." He felt that the excitement of revolutionary times had roused the spirits of the inhabitants to a great height. But, he said, such events are rare, and after they have run their course human affairs return to their usual level.[19]

Whether or not Tocqueville was correct in his estimate of causes, the decline which he saw in American politicians is confirmed by other observers and shows that the falling off in the quality of American medical education was not an isolated phenomenon but was part of a general cultural change. This change can be summarized as the transition from 18th-century Enlightenment to 19th-century Jacksonian democracy.

These two technical terms of historiography require comment, especially with respect to their bearing on the subject under discussion. The Enlightenment consisted essentially of an effort to apply scientific knowledge to the reform of the social order. It was a rationalistic European movement led by illustrious thinkers and writers—such men as Lessing, Newton, Condillac, Diderot, and Voltaire. In the United States its most conspicuous representatives were Benjamin Franklin and Thomas Jefferson. Its influence is discernible also in the meliorism of Benjamin Rush.

Jacksonian democracy takes its name from a coarse and vigorous soldier who reached the presidency and led the nation by fashioning from the majority of ordinary citizens a popular and aggressive political

18. Commager, H. S.: *The American Mind; An Interpretation of American Thought and Character Since the 1800's.* New Haven, Yale University Press, 1950, pp. 10, 361.

19. Tocqueville, A. de: *Democracy in America* [1835, 1840], Bradley, P., editor. New York, Knopf, 1945. 2 v.

party which leaned more toward the unlearned than the learned. Jacksonian policies, moreover, favored the midwest of the United States against the richer and more highly cultured eastern seaboard; they were influenced also by Mr. Jackson's personal antipathy to England.

Therefore, in passing from influences which combined those of the British civilization and European Enlightenment to influences generated by Jacksonian democracy, American culture passed from a system of ideas fashioned by learned Europeans to a parochial complex of actions in which ideology was less conspicuous and in which the ignorant "practical" man strove to equal the educated man and the theorist. This transition necessarily had important consequences. It was, moreover, accompanied by certain specific changes which the American Revolution had introduced, especially disestablishment of the Church of England and the weakening of the legal profession, many of whose leading members had fled to Canada or England. The enfeeblement of centralized ecclesiastical authority and of lawyers' prestige could hardly have failed to affect American attitudes toward a medical profession educated along European lines. As Thistlethwaite[20] put it, "inherited disciplines lost their force and professional standards became coarsened and vulgarized."

It is to be noted, further, that much of American medical practice at this time followed the tradition of the British apothecary more closely than the tradition of the university-educated physician.

It would be misleading to present the story of American medical education in the 19th century as a tale of uncomplicated deterioration. The Americans never were and never have been "perfectly joined together in the same mind and the same judgment." Indeed, attempts at reform were instituted comparatively early. These lie outside the scope of the present discussion. A generous helping of the facts is provided by Norwood[21] and in Fishbein's history of the American Medical Association,[22] an organization that was established as an integral part of the reform movement.

The Care of the Mentally Ill

In discussing the care of the mentally ill in the United States it is

20. Thistlethwaite, F.: *The Great Experiment; An Introduction to the History of the American People.* Cambridge, University Press, 1955, p. 110.
21. Norwood, W. F., op. cit., pp. 422ff.
22. Fishbein, M.: *A History of the American Medical Association, 1847 to 1947.* Philadelphia, Saunders, 1947, 1226 pp.

convenient to draw, inter alia, on the pioneer treatise of Albert Deutsch[23] and on the more recent and more critical work by Gerald Grob.[24] To these I have added an interpretation consonant with the design of the present analysis.

If we view the earliest governmental establishment in British North America in broad historical perspective, we see at once that the colonies lacked part of the apparatus which in England the Catholic Middle Ages had bequeathed to the Protestant Reformation—namely, the hospices and lazar houses, the universities, old hospitals such as St. Bartholomew's and St. Thomas's, and some large special institutions such as Bethlem. Together with this equipment, the Tudors acquired increasingly huge problems of poor-relief.

The history of the British poor laws has been carefully prepared by Dr. William Hartston.[25] In the colonies, for care of the sick poor (including the mentally ill) there was a legal substrate, which was based on the poor laws of Elizabeth I and which determined that each parish was responsible for its own poor. The infamous epiphyte, the so-called settlement laws of 1662, also was transplanted to the colonies. It provided that indigent persons could be expelled from a place if they had not established legal residence ("settlement") there. So far as I have been able to ascertain, the insane were not exempted from this provision. Since the dependent mentally ill were classed with the poor, it is obvious that the determining consideration was economic and not medical.

On the fundamental legal aspects of these problems, an important source of information which rarely, if ever, is mentioned in medical writings is "The Formative Era of American Public Assistance Law," by Stefan A. Riesenfeld, published in the *California Law Review*.[26] In this extensive essay Professor Riesenfeld shows that the law of the early American colonies

> . . . was essentially that of the mother country. This law was, however, not so much the common law which the judges at Westminster administered, as the local law by which the common people lived in the seventeenth century and which we find

23. Deutsch, A.: *The Mentally Ill in America; A History of their Care and Treatment from Colonial Times* [1937]. Second edition. New York, Columbia University Press, 1949.

24. Grob, G.: *Mental Institutions in America; Social Policy to 1875.* New York, Free Press, 1973.

25. Hartston, W.: The care of the sick poor in England. *Proc. Roy. Soc. Med. 59:* 577-82, 1966.

26. Riesenfeld, S. A.: The formative era of American public assistance law. *Calif. Law Review 43:*175-233, 1955.

Chap. ij.

Anno xliij.

An Act for the relieſe of the poore.

The ij. Chapter.

Churchwardens & ſome holders ouerſeers of the poor.

BE it enacted by the authoritie of this preſent Parliament, that the Churchwardens of euery Pariſh, and foure, three, or two ſubſtantiall houſholders there, as ſhall be thought meete, hauing reſpect to the proportion and greatneſſe of the ſame Pariſh and Pariſhes, to bee nominated yeerely in Eaſter weeke, or within one moneth after Eaſter, vnder the hand and ſeale of two or more Juſtices of the Peace in the ſame County, whereof one to bee of the Quorum, dwelling in or neere the ſame Pariſh or diuiſion, where the ſame Pariſh doth lye, ſhall bee called Ouerſeers of the poore of the ſame Pariſh, and they, or the greater part of them ſhall take order from time to time, by, and with the conſent of two or more ſuch Juſtices of Peace, as is aforeſaid, for ſetting to worke of the children of all ſuch whoſe parents ſhall not by the ſayd Churchwardens, and Ouerſeers, or the greater part of them, bee thought able to keepe and maintaine their children. And alſo for ſetting to worke all ſuch perſons maried, or vnmaried, hauing no meanes to maintaine them, vſe no ordinary and daily trade of life to get their liuing by, and alſo to raiſe weekely or otherwiſe (by taration of euery Inhabitant, Parſon, Vicar, and other, and of euery occupier of Landes, Houſes, Tithes impropriate, or Propriations of Tithes, Coleſmines, or ſaleable vnderwoods in the ſaid Pariſh, in ſuch competent ſumme and ſummes of money, as they ſhal thinke fit) a conuenient ſtocke of Flaxe, Hempe, Wooll, Threed, Iron, and other neceſſary ware and ſtuffe to ſet the poore on worke, and alſo competent ſummes of money, for, and towards the neceſſary releefe of the lame, impotent, old, blind, and ſuch other among them being poore, and not able to worke, and alſo for the putting out of ſuch children to bee apprentices, to be gathered out of the ſame Pariſh, according to the

Opening page of the famous Elizabethan poor law (43 Elizabeth I, chap. 2).[20] Courtesy of Library of Congress.

> in the records of the British boroughs, the Quarter Sessions and other local courts. . . . It is probably to the everlasting credit of the lawmakers of the Tudor period that they not only laid the cornerstones for the protection of civil rights but also enacted the legal foundations for the development of public assistance to the needy. . . .[27]

According to Professor Riesenfeld's analysis, the essential feature of the Elizabethan poor law, the principle of local responsibility, was safeguarded by two corollaries: the principle of settlement and removal and the principle of primary family responsibility. In tracing the evolution of these three components he calls attention to an act passed in 1535 which is regarded as the foundation of public relief in England. This law,[28] enacted in the reign of Henry VIII, was followed by a series of statutes of Elizabeth I which created a compulsory system of public assistance and culminated in the famous revised and completed enactment of 1601, customarily designated as 43 Elizabeth I. Dr. Riesenfeld remarks[28a] that ". . . in spite of countless amendments, a radical reform in 1834 and a comprehensive recodification in 1927, it remained one of the formal bases of English relief until the great post-World War II reforms." The essential passages are as follows (see Figure 1).[29]

> *An act for the reliefe of the poore.* The ij. Chapter. Be it enacted by the authoritie of this present Parliament, that the Churchwardens of euery Parish, and foure, three, or two substantiall housholders there . . . shall bee called Ouerseers of the poore . . . and they . . . shall take order from time to time . . . for setting to worke all such persons . . . hauing no meanes to maintaine them, use no ordinary and daily trade of life to get their liuing by, and also to raise . . . competent summes of money . . . for, and towards the necessary reliefe of the lame, impotent, old, blind, and such other among them being poore, and not able to worke

27. Riesenfeld, op. cit., pp. 176-77.

28.. "All governors of shires, cities, towns . . . shall find and keep every aged, poor and impotent person, which was born or dwelt three years within the same limit by way of voluntary and charitable alms in every of the same cities and parishes, &c. with such convenient alms as shall be thought meet by their discretion so as none of them shall be compelled openly to go into begging. And also shall compel every sturdy vagabond to be kept in continual labour. . . ." 27 Henry VIII (1535), chap. 25. Pickering, D., editor: *The Statutes at Large.* Cambridge, Bentham, 1763, vol. 4, pp. 387-88.

28a. Riesenfeld, op. cit., p. 181.

29. Great Britain laws, statutes, etc., 1558-1603 (Elizabeth). Anno xliii. Reginae Elizabethae . . . London, Barker, [1601], chapter 2. See also Pickering, D., editor: *The Statutes at Large.* Cambridge, Bentham, 1763, vol. 7, pp. 30-37.

> . . . and the sayde Justices of peace . . . to sende to the house of correction or common Gaole, such as shall not employ themselues to worke . . . it shall and may be lawfull for the said Churchwardens and Ouerseers . . . To erect, build and set vp in fitte and conuenient places of habitation . . . conuenient houses of dwelling for the said impotent poore, . . . And be it further enacted, that the Father and Grandfather, and the Mother and Grandmother, and the children of euery poore, old, blinde, lame and impotent person, or other poore person not able to worke . . . shall, at their owne charges, relieue and mainetaine euery such poore person. . . .

The settlement laws, mentioned in a previous paragraph, appear in an early form in chapter 3 of 19 Henry VII:

> For as muche as the kynges grace moste entierly desyrethe amonge all other erthly thynges, the prosperytie and the restfulnesse of this his realme, and his subiectes of the same, to lyue quietly and suerly, to the plesure of god and accordynge to his lawes, wyllynge alway of his pitye, and entendynge to reduce theym therto by softer meanes then by extreme rygoure, therfore purueyed in a statute made in the tyme of kynge Rycharde the second, consyderynge also the great charges that shulde growe to his subiectes, for bringynge of vacaboundes to the geales, accordynge to the estatute. His hyghnes wyll, by the auctoritie of this his present parlyment to be ordeined and enacted, that where all suche mysdoers shulde be by examination committed to the common geale, there to remayne as is aforesayde, that the shyryffes, mayres, baylyffes, hyghe constables, pety constables, and other gouernours, and officers of cities, boroughes, and townes, townshippes, vyllages and other places, within thre daies after this act proclamed, make due serch, and take or cause to be taken al such vacabundes, ydel people, and suspecte persons, lyuyng suspecyously, and them to take and set in stockes, there to remayne by the space of one day and one night, and there to haue none other sustynaunce, but breade and water, and after the sayde daye and nyght passed, to be had out and set at large, and than to auoyde the towne or place where they be taken, in to suche citie, towne, place or hundred where they were borne or elles to the place where they last dwelled or mayde theyr abode

> by the space of iii yeres, and that as hastely as they conuenyently maye, and there to remayne and abyde, and yf eftesones they be taken in suche defaute in the same towne or townshippes, than to be set lykewyse in stockes by the space of thre dayes and thre nightes, with lyke dyet as is aforesayde, and yf any person or persons gyue any other meate or drinke to the said misdoers, so being in stockes in fourme aforesayd, or the sayd prysoners fauour in theyr misdoinge, or them receyue or harborowe one nyght, that than they forfeyte for euery tyme so doynge xii d. And also it is ordeyned by the sayde auctorytie, that al maner of beggers not able to worke . . . go, rest and abide in his citie, towne or hundred, where they were borne, or elles to the place where they made last theyr abode by the space of thre yeres, ther to remayne or abyde without beggyng out of the sayd citie, towne, hundred, or place, vpon peyne to be punsysshed as is aforesayde. . . . Prouyded alway that diminution of punishmentes of vacabundes and beggers aforesayd, may and shall be had for women great with chylde, and men and women in great syckenes, and persons beyng impotent and aboue the age of ix yere, by the discretion of hym that hath auctority to do the said punishment. . . .

After this beginning, the settlement laws pursued a course somewhat analogous to that of the poor laws. They were modified under Henry VIII and codified in 1597 under Elizabeth I,[30] and they culminated in the notorious enactment of Charles II, the *Act for the Better Relief of the Poor of this Kingdom.*[31] This statute, prolific of misery, reads in part as follows:

> Whereas the Necessity, Number, and continual Increase of the Poor . . . is very great and exceeding burthensome . . . For Remedy whereof, and for the preventing the perishing of any of the Poor . . . be it enacted . . . That it shall and may be lawful, upon Complaint made . . . to remove and convey such Person or Persons to such Parish where he or they were last legally settled. . . . That from thenceforth there be, and shall be, one or

30. Riesenfeld (op. cit., pp. 188-89) considers the most important enactments to be: a) 11 Henry VII, 1494, c. 2; b) 19 Henry VII, 1503, chap. 12; c) 14 Elizabeth I, 1572, chap. 5; d) 18 Eliz. I, 1576, chap. 3 (sub fin.); e) 39 Eliz. I, 1597, chap. 3, and f) 39 Eliz. I. 1597, chap. 4. To a medical reader untrained in law their importance seems minimal. The texts are to be found in Pickering, D., op. cit., vols. 4, 6, and 7.

31. 13 and 14 Car. II, 1662, chap. 12.

> more Corporation or Corporations, Work-house or Work-houses. . . . That it shall and may be lawful . . . to apprehend, or cause to be apprehended, any Rogues, Vagrants, Sturdy Beggars, or idle and disorderly Persons . . . and to cause them to be kept and set to work in the several and respective Corporations or Work-houses. . . .

In the colonies, although the local authorities were empowered or required to erect almshouses and workhouses,[32] they usually did not do this, except in the most populous places. Instead, the colonial poor were ordinarily supported in their own homes or in those of neighbors. The English settlement laws, however, were adopted and enforced, in order to relieve the parishes of other people's paupers.

With respect to the insane, who at first presented no large problem, the general purposes were protective. The lunatic was protected against himself and the community was protected against him. Especially when they were harmless, the indigent insane were not necessarily immured, but, like other poor persons, were maintained in private homes, financial assistance being supplied by the local authorities. Those who were kept in almshouses were not regularly segregated. Methods often tended to be informal, somewhat haphazard, and hence diverse. A few specimens will illustrate the tenor of the enactments.

The first is from Providence, R. I., which was founded in 1636 and incorporated as a town in 1649:

> The 3rd of Novemb [16]55 (so calld) Roger Williams Moderat: . . . Ordred yt since o[u]r neighbor Pike hath diuers times applied himselfe with Complaints to ye Towne for helps in this his sad Condition of his Wiues distraction he shall repaire to ye Towne Treasurer who js hereby authorized & required (as

32. According to the *Oxford English Dictionary* and the second edition of *Webster's New International Dictionary, Unabridged,* the differences are as follows:

An almshouse is an institution for housing the poor, usually the aged and "deserving," which is founded by private charity and generally managed by a private board of governors. Many such still exist in England, some going back to medieval times, and may be pointed out in guidebooks as interesting survivals. In America, where they are less common, the term is often used interchangeably with poorhouse.

The poorhouse is properly an institution for housing the poor, supported and managed by local government.

The workhouse is a local government institution for housing the poor in which the able-bodied are required to work. In England during the 19th century workhouse conditions were often kept onerous by the guardians of the poor as a means for discouraging paupers from applying for poor relief. In America the term has been used for a house of correction for petty offenders, such as vagabonds and the like. These are the "undeserving" poor, presumed to have been brought to low estate by unwillingness to work rather than inability caused by some misfortune beyond their control, such as accident, sickness, or age.

> moneys Come into his hand) to Pay vnto ye said Pike to ye Summe of fiftie shillings: And ye Towne Promiseth vpon his further want & Complaint, he shall be supplied though to ye Value of 10 £ or more[.][33]

In the colony of New York the Duke of York's Laws were enacted in 1665. Soon afterward the following amendment was made:

> That In regard the Condition of distracted persons may prove of publique Concerne, and for that it is to greate a burthen for one Towne allone to beare, It may bee taken into Consideration at the Assizes whether the other townes of that riding ought not to Contribute to the Charge, and as Care may then be taken therein for the future so some way of Satisfaction may be thought on for extraordinary trouble past. . . .[34]

The records of Connecticut contain the following, under date of July 15, 1680:

> For the poore, it is ordered that they be releived [sic] by the townes where they live, every towne providing for theire own poore; and so for impotent persons. There is seldom any want releife; because labour is deare. . . . Beggars and vagabond persons are not suffered, but when discovered bound out to service. . . .[35]

It appears probable that in these and other colonial records the word "impotent" includes mental disability.

An act passed in Massachusetts in 1693 and copied in Connecticut in 1699 reads as follows:

> An Act for the relieving of Ideots and Distracted Persons. It is ordered. . . . That when and so often as it shall happen any persons to be naturally wanting of understanding, so as to be uncapable to provide for him or her selfe, or by the providence of God shall fall into distraction and become non compos mentis, and no relations appear that will undertake the care of providing for them, or that stand in so near a degree, as that by law they may be compelled thereto; in every such case the select-men or overseers of the poor of the town or peculiar where such person was born or is by law an inhabitant, be and hereby are impowred

33. Rogers, H., Carpenter, G. M., and Field, E., editors: *The Early Records of the Town of Providence.* Providence, Snow and Farnham, 1893, vol. 2, p. 89.
34. *The Colonial Laws of New York, Volume I.* Albany, Lyon, 1894, p. 72.
35. Trumbull, J. H., editor: *The Public Records of the Colony of Connecticut, May, 1678-June, 1689.* Hartford, Case, Lockwood, 1859, p. 300.

> and enioyned to take effectuall care and make necessary provision, for the relief, support and safety of such impotent, or distracted person at the charge of the town or place whereto he or she of right belongs; if the partie hath not estate of his or her own the incomes whereof shall be sufficient to defray the same.[36]

With the advent of the 18th century attempts were made to establish hospitals. As early as 1709 an enterprise of this kind was started by the Quakers of Philadelphia, but it failed. In 1729 and again in 1764 the citizens of Boston, who had had an almshouse at least as early as 1660, proposed to erect one which should separate the distracted from the poor. This also failed, as did a similar effort in Charleston, S.C., in 1754. Meanwhile, in England the first half of the 18th century witnessed the creation of more than a dozen hospitals, five of which were in London.

In considering these facts, Dr. Gerald Grob reasonably concludes that the colonies lagged behind England. While this statement cannot be refuted, an alternative view is at least possible if the early colonial failures are included in the reckoning. The inference then would be that a common culture had given rise to analogous efforts at about the same time in England and America but the colonial effort had failed for lack of capital or of governmental support.

In 1751 the citizens of Philadelphia, acting largely under Quaker influence, combined popular subscription with governmental subsidy and established the Pennylvania Hospital, a general hospital for sick and distempered persons and lunatics. This institution, although aided by the colonial government, was owned by a private corporation. It provided a separate area for the insane. Somewhat later, in 1773, a special asylum was opened in Williamsburg, Va. Built and operated for the insane only, it was the first institution of the kind in the 13 colonies.

In the first quarter of the 19th century several asylums were established. The most notable were the McLean Asylum in Massachusetts, the Friends' Asylum in Pennsylvania, and the Hartford Retreat in Connecticut. By 1825 separate institutions for the insane had been established in eight of the 24 states then existing. In most instances this was done by private citizens who had formed incorporated groups; in a few instances the state government was the founder. There were, in addition, small asylums which were established and operated by individuals.

36. Hoadly, C. J., editor: *The Public Records of the Colony of Connecticut, from August, 1689 to May, 1706.* Hartford, Case, Lockwood, and Brainard, 1868, pp. 285-86.

Almost all of these hospitals were intended for the patient who could pay or for the patient whose community could pay. In almost every instance it was impossible for the hospitals to accept any significant number of patients who could not pay. The system that emerged was therefore dual—the hospitals and asylums served those who brought money, the almshouses served the indigent insane.

The hospitals were now therapeutic, not merely custodial. The principal system was now that of "moral" treatment, the term moral being used in its older sense as virtually equivalent to "psychological" or "spiritual."

The leading influences in America were those which emanated from Philippe Pinel and from the Quakers, namely, the Tuke family of Yorkshire and such American Quakers as Dr. Thomas S. Kirkbride. The general tendency was optimistic. As Grob[37] said, it "led inescapably to the conclusion that if society wished to invest certain resources, the ravages of mental disease could be contained within certain limits, and even might be eliminated in a large percentage of cases." This statement had a parallel in the contention made in the early 20th century by the famous American sanitarian Hermann Biggs, who pronounced that the public health is a purchasable commodity. Both opinions can be placed under the general rubric of American progressivism,[38] but it is surprising—although not altogether unintelligible—that the earlier of these two declarations should have originated in the realm of psychiatry.

The second quarter of the 19th century gave increasing acceptance to the opinion or hope that most mental illness is curable. Also gaining approval was the belief that the sick poor must be sheltered by the government, whether the sick man was sane or insane. This doctrine caused a fundamental change in methods. Many state hospitals were now established for the mentally ill, among the most important being the State Lunatic Hospital at Worcester, Mass., opened in 1833. In addition to state hospitals for the insane, there were many new municipal lunatic asylums and private mental hospitals.

It is usually asserted that American psychiatry at this time was predominantly institutional. Indeed, the statement has been made that because of Pinel's work ". . . the mental hospital became the foundation

37. Grob, op. cit., p. 46.

38. A similar attitude toward the immediate purchasability of public health is apparent in Mr. Richard Nixon's "war" against cancer, declared in 1971. Proverbs 14:15.

upon which psychiatry would develop for much of the nineteenth century. This was especially true in the United States, where private practice in psychiatry was virtually unknown before 1875."[39] Probably the author of this comment had reference only to psychotic or other severely deranged persons, since it is scarcely credible that the ordinary depressive or psychoneurotic—to use the terminology of to-day—was not treated then, as now, by the same physician who treated pleurisy and colic. Changes in the definition of the term "mental disease" and the term "psychiatry" account for the discrepancy. It is, however, incontestable that the leaders of American psychiatry in this era were the hospital superintendents.

With the establishment of state asylums, municipal asylums, and private mental hospitals—all of which were separate from prisons and almshouses—the needs of American society in the realm of mental disease were not satisfied. The services were far from adequate, nor had brutality and corporal restraint been banished. These problems were bequeathed to later decades, including our own.

Such, in brief, is the history of the mentally ill in the United States up to 1850. Some difficult questions must now be asked. Which elements in the historical development can be ascribed to British influence? Which can be ascribed to America itself?

To the Britain of the colonial period we may assign the Elizabethan poor laws and the principle of local responsibility; the settlement laws of the late 17th century; almshouses; confinement of the insane with the aged, the poor, and the sick; lack of pronounced therapeutic intent toward the insane; hospitals; the mixture of public and private mechanisms of charitable and custodial action; Quakerism; and an aristocracy that was at times high-minded and generous.

In order not to distort the analysis, it is necessary to intercalate at this point an influence which belongs in neither the British nor the American category, namely, the work of Philippe Pinel. His dramatic exploits at the Bicêtre and Salpêtrière[40] were approximately simultaneous with the establishment of the York Retreat. By 1806 Pinel's treatise

39. Grob, op. cit., p. 41.

40. For enlightening observations on the treatment of the mentally ill in France during the 18th and 19th centuries see Ackerknecht, E. H.: Political prisoners in French mental institutions before 1789, during the revolution, and under Napoleon I. *Med. Hist. 19*:250-55, 1975.

41. Pinel, P.: *A Treatise on Insanity.* Davis, D. D., translator (London, 1806); P. F. Cranefield, editor. New York Academy of Medicine, History of Medicine Series No. 14. New York, Hafner, 1962.

was translated into English.[41] Benjamin Rush was acquainted with the work of Pinel. At the same time the British and American Quakers were in constant correspondence. From this maze it emerges that in America the influence of the Quakers preponderated over that of Pinel, while the reverse was true on the continent of Europe.

With respect to Pinel I request indulgence for introducing a digression. It is well known that in the 18th century the incarcerated insane were exhibited to the public, who often paid admission fees for the amusing spectacle.[42] Professor Henri Ellenberger[43] of Montreal has brought to light the interesting fact that Pinel, famous for his reforms at the Salpêtrière, was summoned to act as consultant when the Jardin des Plantes undertook the construction of a zoological garden—perhaps on the ancient principle that that which befalleth the sons of men befalleth beasts.

Having considered the British and French components in the history of the mentally ill in America, we must now attempt to select what was specifically American. Colonial America was remote from Europe. The population was small; "they were scattered among the heathen and they were dispersed through the country." The population was diversified regionally. There were various dissenters in the northern colonies, Quakers and Germans in the central colonies, and Anglicans in Virginia. There was a large influx of immigrants, mostly poor, who came chiefly from the British Isles and Germany, bringing with them the unsolved problems of those countries and creating new problems in the new country. The British immigrants can hardly have been at any time a random or average sample of the population of Britain. The localism enforced by the Elizabethan poor laws was reinforced by the diversity of 13 colonies which possessed different systems of government. In the early republic under Federalism, Jeffersonian democracy, and Jacksonian democracy, the federal government was small and its mechanism was almost invisible. In the care of the insane much of the responsibility was left in the hands of private persons, freely and voluntarily associated.

In America the mentally ill for the most part remained with private families until the third and later decades of the 19th century; then

42. Hunter, R. and Macalpine, I.: *Three Hundred Years of Psychiatry.* London, Oxford University Press, 1963, p. 428.

43. Ellenberger, H.: Zoological garden and mental hospital. *Canad. Psychiat. Ass. J. 5*:136-49, 1960 (see esp. pp. 138-39.)

the United States experienced a great wave of construction, during which almshouses and state lunatic asylums were built at the same time as prisons and other public institutions. Even then it is doubtful that the majority of the mentally ill could have been transferred from private to public care.

In the field of mental health, then, the following must be included in a list of American traits and events: lateness in the full development of the almshouse system; lateness in extensive development of the hospital system; creation of state hospitals, headed initially by capable activist physicians; late persistence of physical restraint in institutions for the insane; and late recognition of the value of morbid neuroanatomy. The general pattern is one of delayed development of institutions and characteristics that had appeared earlier in Great Britain. Apart from this, the sole distinctly American element is the influential medical superintendent; the state hospitals which such persons headed had their counterparts in England.

British traditions and mechanisms were not adequate for the problems of mental disease in Britain. When transported across a wide ocean and applied to a population that was at first thinly dispersed and that subsequently increased at a rapid rate, the same mechanisms could scarcely acquire the effectiveness which they lacked at home As the burden was increased by steadily increasing immigration, improved awareness and altered ideals created the pressure for improved methods. Even now, more than a century later, the problems have not been solved.

Conclusion

In this review an attempt has been made to describe the course taken by selected components of British medicine on reaching America. For this purpose two aspects were placed under observation, namely, medical education and the care of the mentally ill. Can any generalization be found which applies to two fields so utterly diverse in character and development?

In the realm of medical education, the colonial Pennsylvanians erected a replica of the University of Edinburgh. Apart from the fact that the colonists selected Edinburgh and not London as their earliest model, it is noticeable that they attempted to duplicate the entire Edinburgh apparatus—professorships, lectures, demonstrations, hospital in-

struction, the baccalaureate degree, and the doctoral degree—but only part of the mechanism proved durable. The baccalaureate degree in medicine disappeared, the lecturing was reduced, licensure atrophied, the entire process was simplified and abbreviated. In later decades a new entity appeared—the proprietary medical school. This apparently was an indigenous invention.

If we return to a consideration of the poor in order to study the insane who were grouped with them, we see that both the Tudor poor laws and the Stuart settlement laws were transmitted to the colonies. The settlement laws were enforced carefully. The poor laws proved to be influential mainly as determinants of local responsibility, but that part of the 17th century system which had to do with almshouses and poorhouses gained little acceptance in America during colonial times. This component of the transmitted culture tarried along the way. Indeed, the construction of almshouses in America did not attain important dimensions until the 1830s and 1840s, when other forces came into action.[44]

We can view the developments, both in medical education and in the care of the mentally ill, as part of the processes whereby cultures are transmitted. The eminent anthropologist A. L. Kroeber[45] made the following comment about marginal cultures:

> . . . the innovations and additions that do reach the edges and peripheries may fail of acceptance by the cultures there, because they involve requirements the receiving culture cannot fulfill. . . . In this way a growing gap may be created, theoretically and often actually, between the culturally productive center and the cultural margin.

It is obviously impossible to predict whether the method of cultural analysis would yield illuminating results if applied to other areas, such as medical practice, medical research, and medical ethics. But the examples which I have presented suggest that this method should be added to the more familiar methods of the social and medical historian, since it may throw new light on transatlantic transformations.

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44. Rothman, D. J.: *The Discovery of the Asylum; Social Order and Disorder in the New Republic.* Boston, Little, Brown, 1971, pp. 180 ff., p. 207.

45. Kroeber, A. L.: *Anthropology.* Revised edition. New York, Harcourt Brace, 1948, pp. 418-19.